DOCUMENT RESUME

ED 172 058 CG 013 483

AUTHOR Austin, Carol D.
TITLE Providing Alternatives to Nursing Home Care: An Interorganizational Analysis.
PUB DATE 16 Nov 78
NOTE 21p.; Paper presented at the Conference of the Gerontological Society (31st, San Francisco, California, November, 1978)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Agency Role; *Community Agencies (Public); Community Health Services; *Delivery Systems; Gerontology; *Interagency Coordination; Interagency Planning; Older Adults; *Organizational Development; Residential Care

ABSTRACT

The development of alternatives to institutionally based long-term care requires the creation of greater interdependence among community based agencies and the provision of appropriate interdependence as the foundation for coordinated service delivery. Theoretical models of interorganizational interdependence are examined and assessed for their utility in understanding issues of community based long-term care services. Assumptions underlying available models (power, symmetry, technological, functional and goal consensus) are critically analyzed for their applicability to long-term care. Case study data from a demonstration project which sought to develop alternatives to nursing home care are presented. Interorganizational power relationships are identified as major explanatory variables with distinctions drawn between symbolic and instrumental interdependence among community agencies. A developmental model of the process involved in creating interdependent delivery systems is presented, including the central conceptual notion of cultural lag, or the distance that must be traversed between recognition of the need for greater interdependence among agencies and their capacity to actually create those circumstances. (Author)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED172058

PRESENTATION DRAFT

Providing Alternatives to Nursing Home Care: An Interorganizational Analysis

by

Carol D. Austin, Ph.D.
School of Social Work
University of Wisconsin-Madison
Madison, Wisconsin

Presented at

31st Annual Scientific Meeting
Gerontological Society
Dallas, Texas
November 16 - 20, 1978

CG013483

Providing Alternatives to Nursing Home Care: An Interorganizational Analysis

Interest in the development of services and programs that might provide alternatives to nursing home care has been stimulated by several recent phenomena. We have witnessed sky rocketing costs in health care, nursing home care in particular, as well as allegations of unsafe and perhaps inadequate or inappropriate treatment in long term care institutions. The tremendous growth of the nursing home industry, when compared to the dramatically uneven development of home health care services demonstrates the virtual monopoly of nursing home care in the delivery of long term care services. Further, projected increases in older age cohorts, which have the greatest rate of nursing home utilization have contributed to the interest in developing programs which will provide a wider range of long term care options to needy client groups. This paper will examine the policy orientation which supports the institutional bias in long term care from an interorganizational perspective, critically analyzing theoretical models and assumptions for their utility in understanding how to cerate more differentiated long term care delivery systems. The experience of the Wisconsin Community Care Organization, a demonstration project which seeks to provide alternatives to nursing home care will be used for illustrative purposes.(1)

Rational and Natural System Models

Interorganizational relationships have been conceptualized in two basic models. The notions of exchange among organizations and interorganizational interdependence are rooted in the rational model of organizational analysis. In this view exchange relationships among members of local networks are negotiated so that individual members can maximize their goal attainment.

Stability of resource acquisition patterns, establishing and maintaining exclusive domains, defending organizational jurisdictions and claims against expansionist moves from other organizations, become the foci of the rational model.

Other analysts (Benson 1975, Zietz 1974, Karpik 1972, Alford 1975, Wassenberg 1971) have argued for the need to see relationships among organizations from a natural systems perspective. Embedded in a larger social reality, they argue, organizations face constraints on their ability to function rationally. This approach focuses attention on the permeability of organizational boundaries to the presures of culture, power and stratification patterns that impose significant parameters on interorganizational relationships.

The dynamic tension between appropriate levels of organizational autonomy and desired states of interorganizational interdependence is a core issue.(2) The theoretical and practical problem of how to structure interdependence among organizations demands that attention be paid to both natural system and rational model dimensions, for elements of both are present. Each will be discussed in turn.

Interdependence Among Organizations

The development of community based long term care programs, which can meet the multiple needs of highly disabled client populations requires the creation of delivery systems which can provide coordinated services. Creating appropriate levels of interdependence among community based agencies is the foundation for coordinated service delivery and represents a particularly acute problem in the elaboration of long term care delivery systems. The concept of interdependence among relatively autonomous organizations has been explored by several analysts.

Interdependence has been identified as a major determinant of inter-organizational linkages. Litwak and Hylton (1962) argued that interdependence is the minimum condition for any form of linkage among organizations. They define interdependence as the conditions in which "two or more organizations must take each other in to account if they are to accomplish their goals." (3) They assert that awareness of interdependence is central to coordination among agencies. It is important to note that Litwak and Hylton are primarily concerned with resources; funding, staff and information. They suggest it is the very real and present scarcity of resources that provides the impetus for agencies to be aware of and perhaps act on their interdependence.

In the social welfare sector, however, a concept of interdependence based solely on scarce resources obscures other important bases for interdependence. Another approach to the concept of interdependence encompasses two dimensions. Aiken et. al (1975) and Hage (1975) suggest that the presence of a functional necessity and a technological imperative propels organizations into joint programs and creates greater interdependence in delivery systems. It is assumed that agencies have reached consensus on the presence of both a functional necessity and a technological imperative.

A functional necessity is said to exist where there is a complex problem that can only be solved by a delivery system of organizations. Client needs are such that adequate service delivery is beyond the scope of a single organization and simultaneous services are indicated. A technological imperative exists when agencies agree that client problems require joint programming. In these situations, the model suggests, it is not necessary to develop new interventive technologies. Rather, it is a matter of merging already existing technologies in a proper sequence reflecting their interdependence.

The Aiken and Hage formulation implies a casual sequence. Joint funding, the mechanism through which interorganizational programs are financed and through which resource interdependence is created, follows consensus regarding the functional necessity and the technological imperative to create greater interdependence in a delivery system.

Organizations' awareness of their interdependence, whether of a resource, functional or technological character, is a complex issue. Given the environment of scarce resources within which health and social welfare agencies operate, it is reasonable to expect that agencies are more acutely aware of their resource interdependence, particularly when there is little consensus about optimal interventive strategies. The rational model perspective suggests that organizations, revolves around negotiation of resource interdependence in their local networks.

Domain Consensus and Exchange Theory

Exchange theory provides another rational approach to understanding relationships among organizations. Levine and White's (1961) notions of exchange and domain consensus are based on concepts of resource interdependence. Elements of exchange among organizations are resources: clients, labor services, capital equipment.. Agency interdependence is said to be contingent on three related factors: the accessibility of each agency to required resources from outside the local system, the organization's particular objectives and functions to which it allocates resources under its control and the degree to which the organizations involved have developed consensus regarding their respective domains. Domain consensus is a way to divide up the resources available within the organizational network and domain negotiations are the mechanism through which turf is negotiated.

Resources associated with the negotiated domain can be claimed legitimately, thereby reducing competition for resources and enhancing the stability of resource distribution patterns to agencies in the network.

Power in the Interorganizational Network

From a natural system perspective both interdependence and domain consensus within interorganizational networks are manifestations of the power relationships that exist among its members. Crozier (1967) has defined the power of one actor over another as control over sources of uncertainty that one party holds vis-a-vis the other. The extent of that power is partially determined by the relative importance of the uncertainties controlled by one actor for the other and the rules by which those power relationships are played. Benson (1975) has argued that two kinds of resources exist within interorganizational networks, money and authority and that the level of interdependence within networks is directly related to uncertain elements controlled by some network members for others.

The natural system perspective emphasizes that external linkages of local network members significantly influence their relative dependence within the local delivery system. The power and authority of an individual agency locally are seen in relation to patterns of macro-structural dominance. Zeitz (1974) claims there has been a reluctance to see interorganizational networks as significantly shaped by community and societal stratification patterns. The rational model implies that organizations are basically equal and unconstrained in their ability to negotiate their interorganizational dependencies. The exchange approach assumes that organizations are generally able to determine the terms of their interorganizational participation. Without the kind of institutional perspective stressed by the natural system model, organizations appear more autonomous than they actually are.

Parameters of interorganizational relationships are determined by patterns of institutional legitimacy which dictate the normative and legal bases of organizations' relations with one another.

Stratification Among Organizations: Consequences for Interdependence

Powerful organizations control uncertainties for others in their interorganizational networks by occupying pivotal positions in the distribution of network resources. They enjoy relative stability in their own resource acquisition capacities. Recognition of stratification, that organizations have differential power, is basic to understanding relationships among organizations. Powerful organizations are linked to prestigious constitutencies that represent the organization's interests in the development and implementation of structural arrangements. The delivery of long term care services is illustrative.

The institutional bias in long term care cannot be separated from the power and influence of the medical establishment and its ability to shape government policy and funding. Coverage available through Medicare and Medicaid has created a situation where the overwhelming majority of long term care services are provided in institutional settings and has structured patterns of resource distribution within local networks that reinforce the dominance of nursing homes. How can we understand the problems of creating interdependence among organizations within a highly stratified social structure, particularly when accomplishing the desired levels of interdependence would dramatically alter the prevailing stratification patterns.

Symbolic and Instrumental Interdependence

The current state of theoretical development suggests the need to differentiate between symbolic and instrumental interdependence, between an awareness

of interdependence and the capacity to structure the kinds of relationships implied in by that awareness. This distinction is particularly significant where the development of desired levels of interdependence would change the nature of macro structural and local network dominance.

Symbolic interdependence relates to ideology and rhetoric. It does not require action. It is relatively easy for health and social service agencies to agree with the ultimate wisdom, justice and humaneness of popular service delivery goals. Prevention of unnecessary institutionalization of individuals, who would rather maintain their own independence and remain in their own homes for as long as possible, are noble goals. Personal independence is a highly valued cultural norm and institutional care has become a costly care modality. Further, there is widespread support for the development of a complete continuum of long term care programs which might provide alternatives to nursing home care through the delivery of coordinated community based services. However, the capacity to implement fully coordinated delivery systems requires the restructuring of relationships among organizations and demands more than symbolic interdependence.

Instrumental interdependence is more than agreement on broad philosophical goal statements. It is based on action in a desired direction. Instrumental interdependence is agencies willingness to behave and make choices differently in the pursuit of service delivery goals. Serious pursuit of the goal of developing alternatives to nursing home care would produce changes in local domain consensus among organizations involved in delivering long term care. Alterations in domain consensus produce shifts in resource distribution patterns and power in local delivery systems. Stratification patterns among organizations engaged in the provision of

long term care services, suggests that dominant organizations in long term care networks will resist the development of instrumental interdependence and prefer to stress the symbolic aspects of their interdependence.

The presence of asymmetrical power relationships in long term care reflects Warren's (1975) concept of an institutionalized thought structure or the prevalent diagnostic paradigm. An institutionalized thought structure provides the ideological and technical foundation for interaction among organizations, shaping structural and procedural relationships. The provision of supportive in-home health and social services as an alternative to nursing home care, the prevalent diagnostic paradigm, challenges the institutional bias in long term care. Warren predicts that innovations which challenge the institutionalized thought structure will be resisted with great intensity. While there may be a shared perception of a shortage of needed services, there is also considerable disagreement about how to close that gap. Certainly the issue of who is the most appropriate recipient of institutional care and who might best benefit from in-home services has vast implications for the domain consensus and resource distribution in local networks. Instrumental interdependence will be an elusive goal.

Applications to Long Term Care

How useful are these theoretical dimensions for enhancing our understanding of the current state of long term care, whether community or institutionally based? A synthesis of the rational and natural system models focuses attention on the impact of contextual parameters and emphasizes the significance of asymmetrical power relationships.

In many communities, nursing homes provide the only form of long term

care that is available. Where in-home health and social services are present they may be available on such limited quantities as to make them inaccessible to potential clients. Consequently, nursing homes can behave autonomously within their local networks. As long as their admission and occupancy rates remain stable and they can bill Medicare and Medicaid directly for the costs of the services provided to residents, nursing homes can be quite independent. In many communities the development of alternatives to nursing home care amounts to introducing competition into the local network, often where none existed before, potentially upsetting previously negotiated domains and threatening the stability of resource distribution patterns.

Power asymmetry, both at the macro and local levels, has produced technological and functional problems. The technological imperatives and the functional necessities for creating interdependence are less observable in monopolistic or highly asymmetrical circumstances. The dominance of institutionally based long term care has created technological and functional limitations which do not facilitate creating appropriate levels of interdependence among organizations. Technologically, there are significant gaps in the areas of community need assessments for long term care services, patient assessments, and knowledge about the consequences of various treatment approaches. It is difficult to project demand for services which do not exist especially where the universe of unmet need is great. While estimates of rates of inappropriate institutionalization may provide a proxy, they are not as accurate as service delivery experience. Problems in establishing appropriate target populations in an incomplete continuum of care make projections of the demand for in home health and social services hazardous.

The institutional bias in long term care also has consequences for

individual client assessment technology. In the absence of a full continuum of care it has not been necessary to develop assessment techniques which make it possible to match an individual's needs to a package of services. As long as nursing home care has been the primary service available, methods for differentiating among client groups have not been needed since few other services were available. Given the absence of community based alternatives there has been limited impetus to develop these technologies. Only recently has there been a proliferation of assessment instruments.(4)

Control of the assessment process is crucial. Professional discretion is high where technology is indeterminate.(5) Efforts designed to reduce the indeterminacy of client assessment, combined with attempts to complete the continuum of long term care, challenge the dominance and autonomy of the medical establishment.

Given the incomplete continuum of care in the delivery of long term care services, consensus about the functional necessity of a coordinated approach to service delivery may be more symbolic than instrumental. It is relatively easy to agree with the necessity of developing a coordinated delivery system, when the continuum of care is incomplete.

Reshaping interorganizational relationships is a challenging task, particularly where few incentives exist to move organizations toward greater states of interdependence. The limited availability of home health services reflects the priorities of current funding. For in-home health and social services to be a real alternative to nursing home care, they must be available in significant volume to make community based programs feasible. It is premature to directly address problems of creating interdependence among community agencies for coordinated delivery of long term care services, if the services themselves do not exist. Awareness of the need to create

greater interdependence among organizations and actually developing those relationships are very different issues.

A Developmental Model

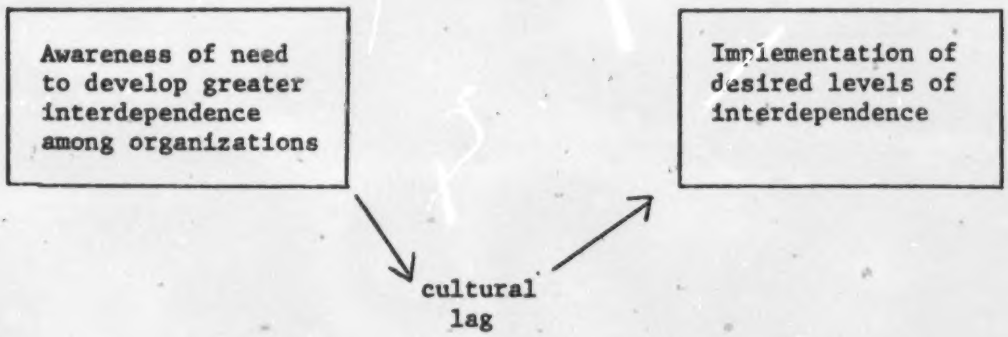
A fruitful area for the further development of interorganizational theory lies in the investigation of the apparent lag that exists between the ability to acknowledge the need for greater interdependence among organizations, and the capacity of those organizations to actually implement the desired relationships. (Figure 1 illustrates this concept). Wassenberg (1970) has aptly noted "...the absence of an integrated theory based on the basic contention that organizations and interests differ in their relative vulnerability to the lags between structural interdependences and cultural repertories for recognizing and handling that interdependence.(6)

The case of long term care suggests indicators of the nature of the cultural lag affecting that service delivery network. The almost monopolistic nature of this delivery system represents a set of interorganizational relationships that falls toward one end of the continuum of interorganizational network characteristics, highly asymmetrical power relationships among organizations. The dimensions of cultural lag that can be identified in the long term care are suggestive of the kinds of variables that should be explored in the future development of interorganizational theory. A significant determinant of the extent of the cultural lag present is the degree of change in macro-structural power relationships that would be necessary to alter the institutionalized thought structure or the prevalent diagnostic paradigm, nursing home care. Some variables of interest might be: the perceived status of the dominant professional group and the organizations in which they work within networks of organizations, their access to decision makers, their ability to influence the structure of program

funding, their professional discretion in situations characterized by indeterminate technology and their control over the distribution of resources within interorganizational networks. Generally, the greater the degree of macro-structural change required to create desired states of interdependence among organizations, the longer the cultural lag between awareness and implementation.

FIGURE I

A DEVELOPMENTAL MODEL OF INTERORGANIZATIONAL INTERDEPENDENCE


Awareness of need to develop greater interdependence among organizations
Implementation of desired levels of interdependence
cultural lag

The Wisconsin Community Care Organization

The history of the Wisconsin Community Care Organization and the problems it confronted as it attempted to develop alternative approaches to nursing home care indicate ways in which parameters governing relationships among organizations engaged in the delivery of long term care have remained essentially unchanged. These can be seen as indicators of cultural lag.

The Wisconsin Community Care Organization was preceded by a demonstration project in the Commonwealth of Massachusetts which uncovered

a critical problem.(7) In the early 1970's there was no way to fund in-home supportive social services which might prove helpful in preventing inappropriate institutional placement. At the time no public resources were available for personal care services. This finding became a fundemental feature of the development of the Wisconsin Community Care Organization. A waiver on the Medical Assistance State Plan in Wisconsin was negotiated in order to fund services for Medical Assistance eligible clients. Hailed as a great breakthrough, the project's experience indicates that the availability of funding alone has not been enough.

The Waiver of the Medical Assistance State Plan was negotiated in 1974. Under the waiver the Wisconsin Community Care Organization possessed broad latitude in developing its program. At its inception the project was unique in its capacity to purchase previously unavailable services for Medical Assistance clients. The uniqueness of the project's funding was seen as its most attractive feature, and the major incentive for community agencies to develop cooperative relationships and coordinated services for clients. As the project developed, however, the waiver's uniqueness was lost as other methods for funding in-home supportive health and social services became available.

The first State Plan for Title XX Social Services in Wisconsin was developed in October, 1975. Goal 4 of the Title XX program provides for the delivery of services aimed at preventing or reducing inappropriate institutional care by providing community based, home based or other forms of less intensive care. With the inclusion of home health services under Title XX it became possible to fund some of the services that had previously required a waiver on the Medical Assistance State Plan to deliver. The combination of services available through the standard Medical Assistance

Program (services not affected by the waiver) and those made possible through Title XX, made it possible to deliver a package of services that was similar to that available through the Wisconsin Community Care Organization. The major limitation to this approach was that Title XX funding is sum certain, and terminates once the funding cealing is reached.

In February, 1977 the Wisconsin State Department of Health and Social Services began the implementation of an expansion of the Medical Assistance Program into home health care. Necessary changes in the Medical Assistance State Plan were approved by the Regional Office of the Department of Health, Education and Welfare. Those services for which a waiver on the Medical Assistance State Plan had been negotiated in 1974 were now included in the standard Medical Assistance Program as services regularly available to eligible recipients. With the implementation of expanded personal care services provided by the unwaived Medical Assistance Program it was no longer clear what distinguished the Community Care Organization Project's capacity to provide home health services. If Medical Assistance clients could receive home health services through the regular program, the waiver no longer seemed necessary.

Although the Medical Assistance waiver made a potentially unlimited new source of funds available, its uniqueness was eroded as it became possible to fund home care services through Title XX and expanded personal care under the Medical Assistance program in Wisconsin. Seeking to fill gaps and avoid duplication of services, the project did not affect other service providers' ability to be reimbursed through Title XX or through the standard Medical Assistance program. Greater interdependence among agencies did not occur. The original incentive for greater interdependence access to previously unavailable funding through the waiver was significantly weakened as other funding mechanisms were developed.

The second major indicator of cultural lag in the Wisconsin Community Care Organization's history concerns its limited power. The project did not have the authority to require that hospitals, nursing homes and agencies provide access to their caseloads or resident populations in order to identify potential clients for the project. If the project was to provide a true alternative to nursing home admission, it would have to serve a population who would in fact be admitted to a long term care facility if it were not for the presence of community based services. Gaining access to this target population has been problematic.

In 1976 a State Wide Alternate Care Task Force was convened by the Wisconsin State Department of Health and Social Services to make recommendations for the State's biennial budget. Recommendations proposed by the Task Force included the development and implementation of a screening mechanism to assess new nursing home care for the first time would be screened for their appropriateness for nursing and personal care services to be delivered at home or in an alternate care facility. To make sure that savings were realized, no Medical Assistance payments would be made to nursing homes unless the initial screening was performed. The Task Force recommended that the initial screening would be performed by assessment unit located in each county department of social services. A pilot test of the screening procedure was suggested in the Community Care Organization's local sites. No further action has been taken on this proposal. In the midst of departmental reorganization the nursing home screening idea was not given a high priority. To date, the three local project sites of the Community Care Organization have not reduced the nursing home admission rates in their communities. Although the project has served some highly disabled clients, it cannot claim that it has necessarily provided an alternative service. The character of the population served represents

the domain the project could negotiate for itself within each local delivery system. Without adequate incentives or sanctions the project has operated with serious constraints, evidence of the cultural lag.

The inconsistencies and contradictions in the Community Care Organization itself and present in its environment demonstrate the current developmental stage of the process of creating appropriate levels of interdependence among long term care agencies. Perhaps the next set of demonstration projects and future changes in legislation, will address the kinds of incentives and sanctions that are necessary to move closer to actually implementing appropriate levels of instrumental interdependence among organizations for the delivery of community based long term care services. The length of time it takes to institute these structural and programmatic arrangements will provide important insights into the nature of the cultural lag we face.

FOOTNOTES

(1) The Wisconsin Community Care Organization is a research and demonstration project jointly funded by the Kellogg Foundation and Medical Assistance funds.

(2) For the classic discussion of this dynamic tension see:
Gouldner, Alvin W., "Organizational Analysis" in Merton et. al. Sociology Today, Basic Books Inc., New York, 1959.

(3) Litwak, Eugene and Lydia Hylton, "Interorganizational Analysis: A Hypothesis on Coordinating Agencies," Administrative Science Quarterly, vol. 6, March 1962, p. 411.

(4) A considerable body of literature has been developed concerning assessment methodologies. Among these are the following:

Bloom, M. and Blenkner, M., "Assessing Functioning of Older Persons Living in the Community", Gerontologist, 10, (1970), pp. 31-37.

Donaldson, S.W., et. al, "A Unified A.D.L. Evaluation Form," Archives of Physical Medicine and Rehabilitation, 54 (1973), pp. 175-179.

Grauer, H. and Birnbom, F. "A Geriatric Functional Rating Scale to Determine the Need for Institutional Care," Journal of the American Geriatrics Society, 23 (1975) pp. 472-476.

Jones, E.W., A Patient Classification for Long Term Care: User's Manual D.H.E.W. Publication No. (HRA) 74-3107, Washington, D.C., December, 1973.

Kahn, R.L. et. al. "Brief Objective Measures for Determination of Mental Status in the Aged," American Journal of Psychiatry, 117 (1960), pp. 326-328.

Lawton, M.P. and Brody, E.M., "Assessment of Older People: Self Maintaining and Instrumental Activities of Daily Living", The Gerontologist, 9, 69, pp. 179-186.

Mahoney, F.I. and Barthel, D.W., "Functional Evaluation: The Barthel Index", Maryland State Medical Journal, 14 (1965), pp. 61-65.

Meer, B. and Baker, J.A., "The Stockton Geriatric Rating Scale" Journal of Gerontology, 21 (1966) pp. 392-403.

Pfeffer, Eric, "OARS Multidimensional Functional Assessment Questionnaire "Duke Center for the Study of Aging and Human Development, Durham, N.C., 1975.

Sherwood, S. et. al "Developing a System for Assigning Individuals into an Appropriate Residential Setting", Journal of Gerontology, 30 (1975) pp. 331-342.

Williams, T.F. et. al, "Appropriate Placement of the Chronically Ill and Aged", Journal of the American Medical Association, 226, (1973), pp. 1332-1335.

(5) For an excellent discussion of professional discretion see Friedson, Eliot, The Profession of Medicine, Dodd, Mead & Co., Inc. 1970.

(6) Wassenberg, Arthur, "The Powerlessness of Organization Theory" in Critical Issues in Organizations, Clegg and Dunkerley (eds) Rontledge and Regan Paul Ltd, London, 1971, p. 92.

(7) See Home Care: An Alternative to Institutionalization, Final Report, Commonwealth of Massachusetts, Department of Elder Affairs, November 1975.

BIBLIOGRAPHY

Aiken, Michael, et. al., Coordinating Human Services, Jossey-Bass, San Francisco, 1975.

Aldrich, Howard E., "Organizational Boundaries and Inter-organizational Conflict" Human Relations 24: 279-82, August 1971

Alford, Robert R., Health Care Politics, University of Chicago Press, Chicago, 1975.

Benson, J. Kenneth, Joseph T. Kunce, Charles A. Thompson, David L. Allen, Coordinating Human Services: A Sociological Study of an Interorganizational network, Regional Rehabilitation Research Institute, University of Missouri - Columbia Research Series No. 6, June 1973

Benson, J. Kenneth, "The Interorganizational Network as a Political Economy," ASQ, Vol. 20, 1975, pp. 229-249.

Benton, J. Kenneth (editor), Organizational Analysis: Critique and Innovation, Sage Publications, Beverly Hills, 1977.

Cook, Karen S., "Exchange and Power in Networks of Interorganizational Relations," Sociological Quarterly, vol. 18, No. 1, Winter 1977.

Crozier, Michel, The Bureaucratic Phenomenon, University of Chicago Press, Chicago, 1963.

Davidson, Stephen M., "Planning and Coordination of Social Services in Multiorganizational Contexts", Social Service Review, vol. 50, #1, March 1976.

Gouldner, Alvin W., "Organizational Analysis" in Merton et. al., Sociology Today, Basic Books Inc., New York, 1959.

Hage, Jerald, "A Strategy for Creative Interdependent Delivery Systems to Meet Complex Needs", Organization and Administrative Sciences, vol. 5, #1, Spring 1974.

Hooyman, Nancy Runkle, "The Practice Implications of Inter-organizational Theory for Services Integration", Journal of Sociology and Social Welfare, vol. 3, #5, May 1976, pp. 558-564.

Kane, R.L. & Kane, R.A., "Care of the Aged: Old Problems in Needs of New Solutions", Science, vol. 200, 26 May 1978.

Karpik, Lucien, "Sociologie economie politique et buts des organizations de production" RFS, 13 (Juillet-Septembre, 1972)

Lawton, Powell M., "Institutions and Alternatives for Older People", Health and Social Work, vol. 3, No. 2, May 1978.

Levine, Sol and White, Paul E., "Exchange as a Conceptual Framework for the Study of Interorganizational Relationships," ASQ, 5, March 1961, pp. 583-601.